Counseling Services _______ Health Services _______

Student ID	
Date of Birth	

ALFRED STATE
Phone: 607-587-4200
Consent for the Release of
Confidential Information
TWO-WAY

I, ____, hereby authorize Alfred State Health and

Wellness Services to disclose/receive records to/from____

mail (provide address) or e-mail (provide email) ____ the following information:

_____ History _____Assessment _____Treatment plan _____Progress with treatment

_____Immunization record _____History and physical examination

_____Other (please specify) ____

The purpose of the disclosure authorized in this consent is to:
____

I understand that my records are protected under the federal regulations governing Confidentiality of Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R part 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that it will automatically expire after 90 days from the date of the signature unless otherwise specified.

I understand that generally Alfred State may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Date_______________________________________

____ ____
Signature of Client Signature of parent, guardian, or authorized representative (when required)

____ ____
Signature of Witness Date

I hereby CANCEL my authorization to release the information outlined in this form.

____ ____
Signature of Client Date

____ ____
Signature of Witness Date

FOR OFFICIAL USE

DONE BY_____________________________ DATE___________________________________